AmeriHealth Caritas Louisiana

Provider Claim Dispute Form

Mail this form, a listing of claims (if applicable), and supporting documentation to:

AmeriHealth Caritas of Louisiana
Provider Dispute Department
P.O. Box 7323
London, KY 40742

A dispute is defined as a request from a health care provider to change a decision made by AmeriHealth Caritas Louisiana related to a claim payment or denial for services already provided. A provider dispute is **not** a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

☐ **First-level dispute** ☐ **Second-level dispute**

Submitter/contact information:	
Name (last, first):	Phone number:

Provider information (correspondence):	
Name (last, first):	Phone number:
Provider address:	City, state, ZIP:
NPI number:	Tax ID:
Date:	
☐ I am a participating provider. ☐ I am **not** a participating provider.	

Member information:	
Name (last, first):	Member date of birth:
Member ID:	

Claim information:	
Claim number:	Billed amount: $
Date(s) of services:	

To ensure timely and accurate processing of your request, please complete the payment dispute section below by checking the applicable reason for your dispute and attach documentation to support this dispute. Documentation should include a copy of the original claim (if available), remittance advice, and a narrative explaining why you are disputing denial of the claim(s).

Reason for payment dispute:

☐ Inaccurate payment
☐ Post-service authorization denial
☐ Denied as a duplicate
☐ Clinical edit limitation or denial
☐ Other: _____
☐ Denied for no primary payer EOB (EOB attached)
☐ Denied for no authorization (service does not require authorization)
☐ Denied for no authorization (authorization number on file:_____)
☐ Untimely filing (proof of timely filing attached)

Additional information: